STATE OF MARYLAND

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2013 Quality and Performance Reporting Requirements (QPRR)

This document contains the 2013 reporting requirements for commercial health benefit plans required to participate in Maryland's Health Benefit Plan Quality and Performance Evaluation System. Commercial health benefit plans, including HMOs, POSs, PPOs, EPOs or other similar entities, shall be required to report specifically on services provided during calendar year 2012. **All reporting will include Maryland-only data; therefore, use of multi-state data as well as rotation of rates from the prior year, are no longer authorized.** In order to differentiate Maryland-only data from book-of-business data, commercial health benefit plans shall determine whether a member is a Maryland resident based on the member's residency in the State of Maryland on December 31st of the 2012 calendar year or their last known address.

All QPRR measures are derived from the following quality and performance measurement tools to address public health issues of particular importance in the State of Maryland:

- The Maryland RELICC Assessment - A newly developed tool customized for the State of Maryland by the National Business Coalition on Health/MidAtlantic Business Group on Health, which focuses on race/ethnicity, language, interpreters, & cultural competency issues
- National Committee for Quality Assurance's *Healthcare Effectiveness Data and Information Set (HEDIS®)- A widely used tool which focuses on clinical performance*
- Agency for Healthcare Research and Quality's *Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey – A widely used tool which focuses on member satisfaction with their experience of care*
- *The Maryland Plan Behavioral Health Assessment – A Maryland-specific tool which focuses on behavioral health issues*
- *The Maryland Health Plan Quality Profile – A Maryland-specific tool which focuses on quality improvement initiatives*

All commercial carriers are required to participate in the Health Benefit Plan Quality and Performance Evaluation System. A carrier may request a *Notice of Exemption* from participating in the Health Benefit Plan Quality and Performance Evaluation System from the MHCC. To submit a written request, a carrier must also present clear evidence that shows the carrier does not meet the minimum criteria for participation as defined by the Code of Maryland Regulations (COMAR) 10.25.08. The MHCC'S regulation, COMAR 10.25.08, requires participation in the Health Benefit Plan Quality and Performance Evaluation System by each carrier that:

- Holds a certificate of authority in the State of Maryland
- Has a premium volume in Maryland for each category of health benefit plan that exceeds $1,000,000
- Has no more than 65 percent of its Maryland enrollees covered through the Medicaid and Medicare Programs (as reported in an annual statement submitted by a carrier to the MHCC that includes premium volume and enrollment percentages for the calendar year preceding the reporting period

Commercial carriers that meet compliance with COMAR 10.25.08 and are required to report to MHCC

HMOs Required to Submit Performance Reports

- Aetna Health, Inc. (Pennsylvania) – Maryland
  Aetna Choice POS, Aetna Health Network Only, Aetna Health Network Option, Aetna HMO, Aetna Open Access HMO, Aetna Quality Point of Service (QPOS)
- CareFirst BlueChoice, Inc.
  BlueChoice, BlueChoice HMO CDH, BlueChoice Opt-Out Open Access, BlueChoice Opt-Out Plus, BlueChoice Opt-Out Plus Open Access, CareFirst BlueChoice
- CareFirst Blue Cross Blue Shield; Group Hospitalization and Medical Services
- Cigna HealthCare Mid-Atlantic, Inc.
  HMO, HMO Open Access, HMO POS, HMO POS Open Access, Network, Network Open Access, Network POS, Network POS Open Access
- Coventry Health Care of Delaware, Inc.
- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
  KP Deductible HMO Plan, KP for Individuals and Families, KP High Deductible Health Plan, KP HSA-Qualified Deductible HMO Plan, KP Select Network HMO Health Plan, KP Signature Network HMO Health Plan, KP Traditional HMO, Added Choice POS
- MD- Individual Practice Association, Inc.
  Choice, ChoicePlus, Select, SelectPlus
- Optimum Choice, Inc.
  Choice, ChoicePlus, Select, SelectPlus
- UnitedHealthcare of the Mid-Atlantic, Inc.
  Choice, Choice Plus/Select Plus, ChoicePlus, Select, SelectPlus

PPOs Required to Submit Performance Reports

- Aetna Life Insurance Company MD/DC
  Aetna Open Choice® PPO
- CareFirst of Maryland, Inc
  Blue Preferred
- Connecticut General Life Insurance Company – Maryland/DC
  CIGNA OAP, CIGNA PPO
- Coventry Health and Life Insurance Company
- Kaiser Permanente Insurance Company
  Flexible Choice PPO
- MAMSI Life and Health
- UnitedHealthcare Insurance Company – Mid-Atlantic
  Choice, Choice Plus, PPO with differential, PPO without differential, Select EPO, Select Plus POS, UnitedHealthcare Navigate Balanced SM, UnitedHealthcare Navigate Plus SM, UnitedHealthcare Navigate SM

A carrier shall report on products individually or in authorized combinations, including combined data for Health Maintenance Organization (HMO)/Point Of Service (POS) products, HMO/POS/Exclusive Provider Organization (EPO), HMO/EPO, and Preferred Provider Organization (PPO)/EPO.

All commercial health benefit plans must use the Interactive Data Submission System (IDSS) tool to submit data for calculation of quality and performance measures.

For questions related to this document, please contact Scharmaine Robinson, Chief, Health Benefit Plan Quality and Performance via email at scharmaine.robinson@maryland.gov or by telephone at 410-764-3483.

2013 QPRR Table of Required Measures

(HEDIS®, CAHPS®, Maryland RELICC Assessment, Maryland Behavioral Health Assessment, and Maryland Health Plan Quality Profile measurement tools)
All measures are subject to audit.

	ITEM	DESCRIPTION	NOTE
LEGEND	A	Measure is required for 2013 reporting by Commercial Health Benefit Plans.	For all required measures listed below as "A," "B" or "C", all of the indicators (or numerators) are required for reporting (e.g., for the CDC measure, the HbA1c < 7 indicator is required for reporting).
	B	Measure is required for 2013 reporting by Commercial Health Benefit Plans; however, being a first year measure, the results will not be publicly reported.	
	C	Measure is required for 2013 reporting by Commercial Health Benefit Plans and includes, for each IDSS submitted, a separate submission that provides member-level file data for each member that is counted in the eligible population for the identified measure (similar to the Patient-Level Data File required for Medicare Managed Care Contractor organizations). See pages 7-8.	
	<blank>	Measure is not required for 2013 reporting.	--

Collection Method	Measure	Accreditation	Required
HEDIS 2013, Effectiveness of Care ®			
Prevention and Screening			
Admin or Hybrid	Adult BMI Assessment *(ABA)*	*	**A**
Admin or Hybrid	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents *(WCC)*	*	**A**
Admin or Hybrid	Childhood Immunization Status *(CIS)*	*	**A**
Admin or Hybrid	Immunizations for Adolescents *(IMA)*		**A**
Admin or Hybrid	Human Papillomavirus Vaccine for Female Adolescents *(HPV)*		**A**
Admin or Hybrid	Lead Screening in Children *(LSC)*		
Admin only	Breast Cancer Screening *(BCS)*	*	**A**
Admin only	Cervical Cancer Screening *(CCS)*	*	**A**
Admin or Hybrid	Colorectal Cancer Screening *(COL)*	*	**A**
Admin only	Chlamydia Screening in Women *(CHL)*	*	**A**
Admin only	Glaucoma Screening in Older Adults *(GSO)*		
Admin or Hybrid	Care for Older Adults *(COA)*		
Respiratory Conditions			
Admin only	Appropriate Testing for Children With Pharyngitis *(CWP)*	*	**A**
Admin only	Appropriate Treatment for Children With Upper Respiratory Infection *(URI)*	*	**A**
Admin only	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis *(AAB)*	*	**A**
Admin only	Use of Spirometry Testing in the Assessment and Diagnosis of COPD *(SPR)*	*	**A**
Admin only	Pharmacotherapy Management of COPD Exacerbation *(PCE)*	*	**A**
Admin only	Use of Appropriate Medications for People With Asthma *(ASM)*		**A**

Admin only	Medication Management for People With Asthma *(MMA)*		**A**
Admin only	Asthma Medication Ratio (AMR)		**B**
Cardiovascular Conditions			
Admin or Hybrid	Cholesterol Management for Patients With Cardiovascular Conditions *(CMC)*	*	**A**
Hybrid only	Controlling High Blood Pressure *(CBP)*		**A**
Admin only	Persistence of Beta-Blocker Treatment After a Heart Attack *(PBH)*	*	**A**
Diabetes			
Admin or Hybrid	Comprehensive Diabetes Care *(CDC)*	*	**A**
Musculoskeletal Conditions			
Admin only	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis *(ART)*		**A**
Admin only	Osteoporosis Management in Women Who Had a Fracture *(OMW)*		
Admin only	Use of Imaging Studies for Low Back Pain *(LBP)*	*	**A**
Behavioral Health			
Admin only	Antidepressant Medication Management *(AMM)*	*	**A**
Admin only	Follow-Up Care for Children Prescribed ADHD Medication *(ADD)*	*	**A**
Admin only	Follow-Up After Hospitalization for Mental Illness *(FUH)*	*	**A**
Admin only	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)		
Admin only	Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)		
Admin only	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)		
Admin only	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)		
Medication Management			
Admin only	Annual Monitoring for Patients on Persistent Medications *(MPM)*		**A**
Admin only	Medication Reconciliation Post-Discharge *(MRP)*		
Admin only	Potentially Harmful Drug-Disease Interactions in the Elderly *(DDE)*		
Admin only	Use of High-Risk Medications in the Elderly *(DAE)*		
EOC Measures Collected Through Medicare Health Outcomes Survey			
Survey	Medicare Health Outcomes Survey *(HOS)*		
Survey	Fall Risk Management *(FRM)*		
Survey	Management of Urinary Incontinence in Older Adults *(MUI)*		
Survey	Osteoporosis Testing in Older Women *(OTO)*		
Survey	Physical Activity in Older Adults *(PAO)*		
EOC Measures Collected Through the CAHPS Health Plan Survey			
Survey	Aspirin Use and Discussion *(ASP)*		**A**
Survey	Flu Shots for Adults Ages 50–64 *(FSA)*	*	**A**
Survey	Flu Shots for Older Adults *(FSO)*		
Survey	Medical Assistance With Smoking and Tobacco Use Cessation *(MSC)*	*	**A**
Survey	Pneumococcal Vaccination Status for Older Adults *(PNU)*		

HEDIS 2013, Access/Availability of Care ®			
Admin only	Adults' Access to Preventive/Ambulatory Health Services *(AAP)*		**C**
Admin only	Children and Adolescents' Access to Primary Care Practitioners *(CAP)*		**C**
Admin only	Annual Dental Visit *(ADV)*		
Admin only	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (*IET)*		**A**
Admin or Hybrid	Prenatal and Postpartum Care *(PPC)*		**A**
Admin only	Call Answer Timeliness *(CAT)* **This measure is not required to be reported as a Maryland-specific measure for 2013 reporting.*		**A**
HEDIS 2013, Experience of Care ®			
Survey	CAHPS Health Plan Survey 5.0H, Adult Version *(CPA)*		**A**
Survey	CAHPS Health Plan Survey 5.0H, Child Version *(CPC)*		
Survey	Children With Chronic Conditions *(CCC)*		
HEDIS 2013, Utilization and Relative Resource Use ®			
Utilization			
Admin or Hybrid	Frequency of Ongoing Prenatal Care *(FPC)*		
Admin only	Well-Child Visits in the First 15 Months of Life *(W15)*		**A**
Admin only	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life *(W34)*		**A**
Admin only	Adolescent Well-Care Visits *(AWC)*		**A**
Admin only	Frequency of Selected Procedures *(FSP)*		**A**
Admin only	Ambulatory Care *(AMB)*		**A**
Admin only	Inpatient Utilization—General Hospital/Acute Care *(IPU)*		**A**
Admin only	Identification of Alcohol and Other Drug Services *(IAD)*		**A**
Admin only	Mental Health Utilization *(MPT)*		**A**
Admin only	Antibiotic Utilization *(ABX)*		**A**
Admin only	Plan All-Cause Readmissions *(PCR)*		**A**
Relative Resource Use			
Admin only	Relative Resource Use for People With Diabetes *(RDI)*		**A**
Admin only	Relative Resource Use for People With Cardiovascular Conditions *(RCA)*		**A**
Admin only	Relative Resource Use for People With Hypertension *(RHY)*		**A**
Admin only	Relative Resource Use for People With COPD *(RCO)*		**A**
Admin only	Relative Resource Use for People With Asthma *(RAS)*		**A**
HEDIS 2013, Health Plan Descriptive Information/Stability ®			
Admin only	Board Certification *(BCR)* **Report results for this measure by limiting the reporting to include only providers that are actively licensed to practice by the Maryland Board of Physicians and have an office or a physical presence in the State of Maryland.*		**A**
Admin only	Enrollment by Product Line *(ENP)*		**A**
Admin only	Enrollment by State *(EBS)*		**A**
Admin only	Language Diversity of Membership *(LDM)*		**A**
Admin only	Race/Ethnicity Diversity of Membership *(RDM)*		**A**
Admin or Hybrid	Weeks of Pregnancy at Time of Enrollment *(WOP)*		
Admin only	Total Membership *(TLM)*		**A**

CAHPS 5.0H, Adult Version Survey ®			
Member Survey	Overall Ratings (of Healthcare, Personal Doctor, Specialist, Health Plan)		**A**
	Composite Care Scores (for Coordination of Care, Getting Care Quickly, Getting Needed Care, Shared Decision Making, How Well Doctors Communicate)		**A**
	Composite Carrier Scores (of Customer Service, Claims Processing, and Plan Information on Costs)		**A**
	Supplemental Questions-Maryland: <None.>		
Maryland RELICC Assessment			
Admin only	Plan Profile		**A**
Admin only	Race/Ethnicity, Language, Interpreters & Cultural Competency		**A**
Maryland Plan Behavioral Health Assessment			
Behavioral Health Measures (Mental Health/Chemical Dependency)			
The template for each of these measures shall be provided by the audit vendor	Percentage of Enrolled Members with Behavioral Health Benefits		**A**
	Percentage of Enrolled Members with Behavioral Health Benefits Served by an External Provider/MBHO		**A**
	Provide All Accreditation Information for Any Segment of Your Health Plan Directly Responsible for Behavioral Health Services That has Received Accreditation (Name, Accreditation Status, and Date of Accreditation Expiration)		**A**
	Provide Name, Accreditation Status, and Date of Accreditation Expiration of Any External Entity that Provides Behavioral Health Services to Plan Members Through a Contractual Arrangement with Your Plan.		**A**
	Provide the Number of **Maryland Providers** from the Available Behavioral Health Network by Discipline (Psychiatry, Psychology, Social Work, Nurse Psychotherapists, Certified Professional Counselors, and Licensed Clinical Alcohol and Drug Counselors) **As Well As the Plan Overall Service Areas**.		**A**
	Percentage of Network Psychiatrists **Located in Maryland and Plan Overall Service Areas** Who Are Board Certified.		**A**
Maryland Plan Quality Profile			
Plan shall provide a Quality Profile to the audit vendor	Each Plan shall submit a two to three page summary of their quality assurance and quality improvement initiatives. The summary shall be consistent with the 2013 theme of: "Leadership Actions In Healthcare Delivery". The theme shall focus on actions taken by each organization's leaders toward progressive programs that respond to the Affordable Care Act, changes in demographics, required services, and patient expectations.		**A**
	Accountability/Access/Disparities/Outreach In addition, each Plan shall submit a list of products under their HMO and PPO delivery systems.		**A**

Automated Source Code Review Measures for 2013 include:

- Asthma Medication Ratio (AMR)
- Annual Monitoring for Patients on Persistent Medications (MPM)

2013 Required Measures for Supplemental Member Level Detail File Submissions

1. **AAP Detail File - Adults Access to Preventive/Ambulatory Health Services**
2. **CAP Detail File -Children & Adolescents' Access to Primary Care Practitioners**

For each submitted IDSS, the organization will submit separate member specific data for each member that is counted in the AAP and CAP measures respectively, similar to the Patient-Level Data File required for Medicare Managed Care Contractor organizations. This member-level file submission shall be due by August 1st, 2013. It should be noted that since both of these measures are first-year measures that are required for detail file submission reporting to MHCC, therefore health benefit plan performance in 2013 on these detail file measures will not be publicly reported.

The Member Level Detail File is to be submitted as a fixed-width ASCII text file. The final file layout for the Member Level Detail File is shown on the following page. All fields are required to have a valid value. Data elements being collected include the following:

- Organization Name
- Product Type
- Member's Payer-Encrypted ID
- Member's Gender
- Member's Date of Birth
- Member's Race/Ethnicity
- Method of Determination for Member's Race/Ethnicity
- Member Months
- Date of Visit for Numerator Compliance

It should be noted that rather than using the Names (and Member ID) of each member, a unique, randomly generated, payer encrypted identification number shall be used instead. The payer-encrypted identification number shall be generated by the Health Benefit Plan to identify each of the members in the file. The payer-encrypted identification number shall be consistent with the payer-encrypted ID number used by the Health Benefit Plan for Medical Care DataBase (MCDB) reporting to the Maryland Health Care Commission (MHCC).

Also to further protect a member's protected health information, rather that listing the complete date of birth for each member, instead substitute two zeros for the day component of the member's date of birth (e.g., mm00yyyy).

Regarding race/ethnicity reporting, the direct method of reporting on race/ethnicity is preferred and Health Benefit Plans should make every reasonable effort to obtain direct information when sources are available. For Health Benefit Plans that do not have race/ethnicity information directly available on the commercial population, the use of indirect methods to gather and report on this information has been authorized. Health Benefit Plans should be able to match the information gathered from geocoding, surname analysis and other indirect methods, to each member that is counted in the eligible population for this measure. Once the matching is done, the appropriate member-level value surrounding race/ethnicity will be able to be assigned to each member of the eligible population based on which race/ethnicity category received the highest probability.

The member specific data should match the numbers for the denominator and numerator for each measure. For the numerator, please provide the date of service upon which numerator compliance was determined. If the member was noncompliant, please list zeros for the date of compliance instead. Total members in the AAP and CAP files should match the total eligible population for the AAP and CAP measures respectively, as reported in the IDSS year.

Format for
Supplemental Member Level Detail File Submissions

1. AAP Detail File - Adults Access to Preventive/Ambulatory Health Services
2. CAP Detail File -Children & Adolescents' Access to Primary Care Practitioners

Data Element	Position	Description
Organization Name	1-30	List name of organization, abbreviate to fit in the space provided. (Left justified)
Product Type	31-37	Options are: HMO, HMO Combo (POS/EPO/other), PPO, PPO Combo (POS/EPO/other). (Left justified)
Member's Payer-Encrypted ID	38-67	List the member's unique identifier; up to 30 alpha-numeric characters. (Left justified)
Member's Gender	68	List the gender of the member; either 'M' (male) or 'F' (female)
Member's Date of Birth	69-76	Substitute two zeros for the day component of the member's date of birth, in the format mm00yyyy
Member's Race/Ethnicity	77-80	The member's race/ethnicity as defined by the footnote below. (Left justified)
Method of Determination for Member's Race/Ethnicity	81	In order to differentiate whether the member's race/ethnicity has been determined by the DIRECT or INDIRECT method, please list "D" to indicate that race/ethnicity determination was by any direct method or "I" to indicate that race/ethnicity determination was by any indirect method.
Member Months	82-83	The number of months the member was enrolled during the measurement year.
Date of Visit for Numerator Compliance	84-91	If a member is compliant for this measure, report the date of service in the format of mmddyyyy. If a member is noncompliant for this measure, report the date of service as zeros (e.g., 00000000).

Race/Ethnicity Codes to Use:

WH – White
BL – Black or African American
AI – American Indian/Alaska Native
AS – Asian
NH – Native Hawaiian or Pacific Islander
HI – Hispanic/Latino
OT – Other
TM– Two or More Races
UN – Unknown
DA– Declined to Answer